

Potential Health Risks Associated with Consumption of Shallow Well Waters in Informal Settlements in Dar es Salaam, Tanzania

Abstract

This paper explores the risks associated with the usage of private water supply from shallow wells in informal settlements in Dar es salaam, Tanzania. Studies on spatial location of water sources used by water vendors in relation to potential sources of contaminants in Tanzania are scant in literature and therefore little is documented on the potential health risks posed by such water sources. Data were collected through documents, household survey and interviews with officials and local leaders at Nyambwera and Tamla Sub-wards in Dar es Salaam. Correlations were calculated between variables by spearman's correlation analysis. It was observed that the distance between the wells and pit latrines for most of the households was less than 10 meters which is far below the acceptable standards of 30 m ($p=0<0.001$). Given the fact that most plots in the study areas have sizes ranging from 120 m² to 300 m² and plot coverage is beyond 90%, space for proper construction of sanitary facilities and shallow wells was extremely limited. The study recommends for close cooperation between sub ward leaders, ward officer and health officials to prevent drilling of wells in close proximity to pit latrines.

1. Introduction

The provision of potable water service in informal settlements especially to the poor households remains a critical challenge for the realization of sustainable urban development. Generally, people living in informal settlements are disadvantaged due to lack of public services such as piped water supply, high population density, and low levels of sanitation [1]. While only 30% of urban inhabitants have access to piped water, 60% of the population relies on other sources of water including shallow wells for their daily consumption [2]. Cheaper borehole drilling technology facilitates the drilling of such shallow wells [3]. Tanzania, just like many other developing countries has not managed to provide safe, clean drinking water to its citizens [4]. This is inconsistent to the country's National water policy of 1991, which states that citizens should have access to clean and safe water within 400 metres by 2002 [5]. Rural populations in developing countries have a higher proportion of the total population without access to clean and safe water. However, the fastest growing population with no access to safe drinking water reside in urban and peri-urban areas [6]. In general, there are improvements in the number of urban

populations connected with safe water but these improvements are compromised by the rapid increase in the number of urban dwellers living in informal settlements [7].

Residents in informal settlements largely depend on water which is supplied by private individuals. Such individuals obtain the water from different sources such as shallow wells, water kiosks, stand-pipes and boreholes [8]. In some African Cities, the proportion of the inhabitants served by water vendors may range from 20–30% [9] to as high as 90% [10]. Therefore, water vendors fill the demand of water supply gap experienced by informal settlers although they (water vendors) carry out their operations outside the legal frame work.

Water vendors use different means to supply water to households; these include door to door delivery, where they carry the water in some containers and sometimes they supply through piped water connections. However, the reliability [11], quality [12] and affordability [13] of the water supplied by these suppliers remain a subject of concern. Due to unsafe and insufficient water supply in urban areas, water borne diseases such as cholera have been prevalent. For example in 1997, 3220 cases of water borne disease and 128 deaths were reported in Ilala District in Dar es Salaam city alone. In 2001, regions such as Kigoma, Arusha, Shinyanga, and Dodoma in Tanzania were also affected by cholera. Cholera in Ilala District affects people living in low-lying flat areas where the water table is high. These areas depend on shallow wells as a source of domestic water. The wells especially those located in close proximity to pit latrines, are prone to contamination by human excreta [14].

Several studies on informal water supply in urban areas have been carried out; see for example [3; 8; 15]. These studies, however, have so far not done any spatial analysis of the locations between pit latrines and the water wells to explore the potential health risks associated with the consumption of such water. Studies on spatial location of water sources which are used by water vendors in relation to potential sources of contaminants in Tanzania are scant. Therefore, little is documented on the potential health risks posed by such water sources in relation to spatial location of pit latrines in the informal settlements.

Therefore this study explores the risks associated with private water supply undertakings in informal settlements in Dar es Salaam city. The exploration was done through mapping and

analyzing water sources by water vendors in relation to the locations of pit latrines, exploring awareness rate and perception of water users and vendors on the potential health risks associated with the consumption of such waters. The study findings are intended to raise awareness on the potential risks associated with water consumption delivered by water vendors.

2. Materials and methods

2.1 Study area

This study was carried-out in Nyambwera and Tamla streets located in Tandika ward, Temeke District, Dar es Salaam. Dar Es Salaam city is located on the Eastern part of Tanzania between $6^{\circ} 34'$ and $7^{\circ} 10'$ South along Indian Ocean coastal line (Fig 1).

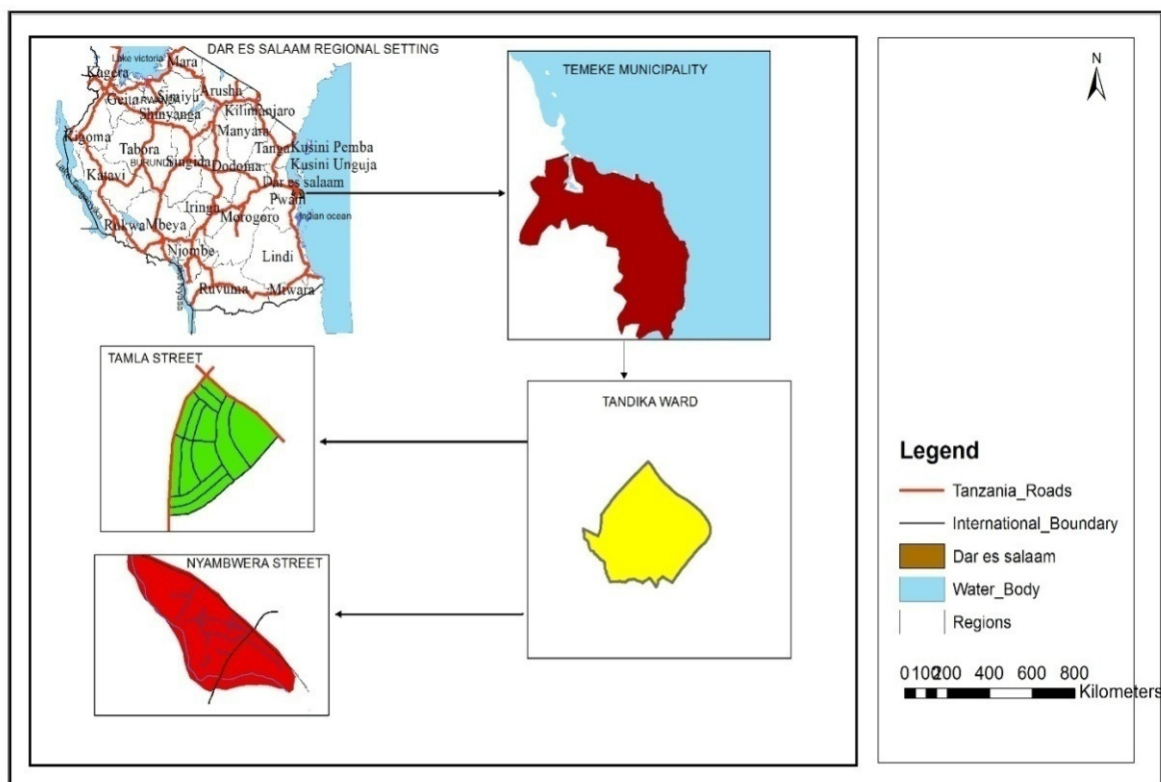


Figure 1: Location Maps of the case study areas

The study area is boarded by the Indian Ocean on the East and Pugu on the west. According to the population census of 2002 [16], Nyambwera and Tamla had a total population of 15354; 8,294 people in Nyambwera and 7060 inhabitants in Tamla. The area had an average household size of 5 persons per household; therefore, the total number of households in the studied population is estimated to be 3070. Temeke District was selected because despite having five

municipalities in Dares Salaam, Temeke is the least serviced with piped water supply [17]. Nyambwera and Tamla sub-wards were selected as a case study area because they comprised of informal settlements with characteristics such as lack of access to sanitation and unreliable piped water, poor roads condition and high density. Most households depend on the water from shallow wells. Pit latrines and septic tanks are used as a means of sanitation. People with high income drill shallow wells for personal use and commercial purposes.

2.2 Sampling

A total of 350 samples households were obtained by using the sampling formula below with the accuracy of 95%.

$$s = \frac{N}{1 + Ne^2}$$

Where: S = sample size; n = number of population; e = error (level of confidence).

To map sources of water, local government leaders at sub-ward level were consulted for the purpose of identifying different sources of water used by vendors and the inhabitants. Details on the spatial locations of wells in relation to the location of pit latrines were taken using Global Positioning System (GPS) and entered on the base map after being digitized based on satellite imagery (12/13/2015) with Arch Map software.

2.3 Data collection

Household survey was carried out to explore awareness and perception of water users and the water vendors on the health risks associated with the consumption of well waters. Questionnaires were administered to 350 households to obtain information concerning major domestic water sources and the perception on water sources safety. Official interviews were carried-out to sub-ward leaders, Dar es Salaam Water Supply Company (DAWASCO) officials and health officers. Ward officers and sub-ward leaders provided information on the boundaries of Tamla and Nyambwera sub-wards, water supply systems in the area, the number of wells available, well owners, sewage system, prevalence of water borne diseases and the existing water vendors.

Water vendors and well owners were interviewed to solicit information on water safety perception in terms of water treatment before delivery and cleanliness of water storage vessels. Other types of information were collected from DAWASCO and these include the percentage of houses that have been connected with water taps and accepted standard distance between wells and pit latrines. Information collected from households' survey was analyzed using SPSS software, and information on spatial locations of shallow wells and pit latrines was analyzed using GIS software. Correlations were calculated between variables using spearman's correlation analysis ($p=0.05$). Furthermore, the normality of the data on the distance between pit latrines was checked using QQ plot in SPSS. Data were analyzed to ascertain if there is any significant difference in distance between pit latrines and the wells against the set standards using a z test ($p=0.05$).

3. Results and discussion

3.1 Socio-economic attributes

According to sub ward and ward leaders, residents of Tandika ward engage in petty trade, selling of clothes and food vending as sources of income. There are some residents who engage in small scale industry activities and those who are employed in various government sectors such as finance, education and health. From household interviews, 40.8% of the people were unemployed; 45.8% were employed in the informal sector; and 13.4% were employed in the formal sector. Employment status determines the level of income and often dictates the water sources a household opt to use [18]. People with stable income have access to clean water supply.

The monthly income levels in the case study areas are presented in Table 1. The greatest proportion of the respondents earns more than 100,000 TZS, per month followed by those earning between 60,000 and 80,000, and finally those earning between 20,000 and 60,000 TZS. Those earning between 80,000 and 100,000 TZS were the least in proportion. This implies that about 70 % of the respondents had monthly incomes of less than 100,000 TZS. Only 30 % had monthly income of higher than 100,000 TZS. 1 USD is equivalent to 2250 TZS.

141 Table 1: household average income

Income levels (TZS)	Percentage
20000 - 60000	23.3
60000 - 80000	27.5
80000 - 100000	18.4
100000 +	30.8
Total	100

142
143
144 From the data in Table 1, it is evident that the majority of residents live in abject poverty. Lack
145 of water and sanitation services in the area will add more pressure on people's lives [19] and as a
146 result increase the burden of hardships in their lives. To complicate the problem even further,
147 water supplied by private vendors is more expensive but of poor quality than the water supplied
148 by DAWASCO (see Section 3.4). These findings are in line with what was reported by [20] that
149 in Morogoro, the private water vendors resold water at 4 times higher than the price of public
150 agencies (e.g. MOROWASA) for domestic water. Households with average income of between
151 20000 TZS and 80000TZS were depending on the water directly from wells. Those earning from
152 TZS 80,000 to TZS 100,000 depend on water vendors and wells for the supply of domestic water
153 whereas those earning 100,000 and above depended on water vendors, tap water and wells for the
154 supply of domestic water. This shows that affluent people had multiple sources of water. Study
155 findings reveal further that those with multiple sources of water supply used tap water, which is
156 the safest source for cooking, drinking and washing utensils, and used water from wells largely
157 for flushing toilets, washing clothes and gardening. These findings are consistent with those
158 obtained in Uganda which show that affluent residents in different cities had multiple sources of
159 domestic water supply and that they (affluent individuals) had more access to piped safe water
160 than was the case with the poor who depend on shallow well waters [21].

161
162 The Spearman's correlation analysis revealed that there is a significant relationship, ($r=19.3\%$),
163 ($p=0.034$) between water sources for domestic use and employment. This signifies that
164 employment status, which determines income levels, predetermines water sources that a
165 household opts to use. Those who are engaged in formal employment earn more and have a
166 stable income compared to those who are unemployed and engaged in informal employment.

Although significant, the existing relationship was weak signifying that there are other factors which influence households' choices of a particular type of water source. These results are consistent with other findings reported elsewhere [8]. It has been found that on daily basis poor households had to make decisions as to which water sources to use depending on how much money is available to purchase the water. Since the majority of the low income earners in peri-urban population in developing countries opted for cheaper water supply sources. If the cheaper sources happen to be unsafe as it has been observed in this study (see section 3.5), the health of the poor residents is put in jeopardy.

3.2 Infrastructure

From the interview carried out with ward leaders, Tandika has one tarmac road which connects Tandika ward with Ubungo District. All access roads are earth roads which lack side drainage systems and are poorly maintained. Lack of central sewage and drainage system provide an opportunity for storm water to flow into shallow wells. This trend contaminates the water and may lead to the outbreak of diseases [19; 15]. Contamination pressure was found to be fueled by the tendency of releasing septic effluents to the flowing water by the residents in poorly serviced areas during rainy seasons. Contamination of piped water as a result of poor disposal of human excreta was especially caused by a flow of sewage in open ditches which are close to leaking water pipes [13]. The septic effluents ultimately end up entering shallow wells and sometimes in piped water systems with leaks [13]. This practice is a potential source of cholera and other water borne diseases in Dar es Salaam especially during rainy seasons. Dar es Salaam has been experiencing annual recurrence of cholera during rainy seasons. The study findings show that private water vending at Tandale ward was not organized. There are no guidelines on how they should operate. They use the same containers for delivering water to customers from different sources. For example they may use a 20 litres container to carry water from shallow wells for a customer 'A' and then the same container will be used to deliver tap, safe water to a customer 'B'. This poses a potential danger of contamination. In contrast with what has been observed in the present study, [22] reported that private water vending in Onisha area in Nigeria is well elaborated and well organized as a result of well-placed legislation that governs water vending operations by the private sector [23]. This is a testimony that if authorities set standards and,

recognize the private sector in the provision of water and sanitation systems the private water vending can offer safe services. According to an interview with the Sub ward leaders and the DAWASCO officials, it was evident that the authorities had turned a blind eye to this informal water supply system. If this trend is left to continue, residents in informal settlements will continue getting water of questionable safety.

3.3 Sources of water by private water suppliers

Findings of household's survey in the present study indicate that the majority of the respondents (50%) depend on water which is purchased directly from wells (Figure 2) as the main source. Water from shallow wells has been reported to be prone to contamination rendering it unsafe for human consumption [24]. The consumption of such water may contribute to the prevalence of water borne diseases. On the other hand, 25% of the households were getting water from water vendors who sell the water from door to door, and only 7.5% of the households received water from DAWASCO.

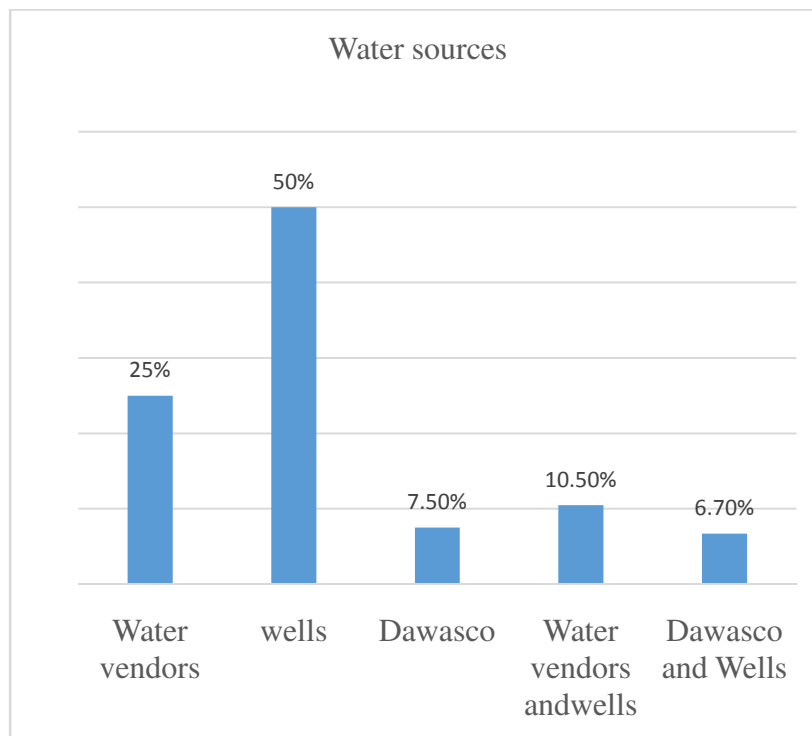


Figure 2: Households water sources

At Tamla and Nyambwera sub-wards, most of the houses had no water pipe connections and the ones that are connected do not regularly get the service. Water vendors get the water for sales from 25 wells which were found within the site. Out of the 25 wells, one was owned by the government and the remaining 24 were privately owned. The depth of the wells at the case study area ranged from 10 m to 120 m deep. According to the ward executive officer, the number of wells increased with time due to increased demand which is aggravated by the growth of population and the shortage of piped water.

3.4 Price charged by water vendors

According to the interview carried-out with water vendors as well as household's information, the price charged depended on different factors such as the type of water, location of water sources, the means used to deliver the water, availability of water and the cost incurred to get the water. According to water vendors, salt water, was charged for 200TZS per 20litres due to the fact that the water is easily available within the site and the cost of purchasing it was 150-300TZS per 120litres -200litres, respectively. On the other hand, fresh water was charged for 500TZS per 20litres. The prices varied in accordance with distance from water sources and the cost incurred in buying such water, and the quality of water. Water vendors get fresh water far away from the site. Vendors at Nyambwera sub-ward get piped water from an area called Veterinary which is located 1 km from Nyambwera; while vendors at Tamla sub-ward get piped water at 800m away at a cost of 100TZS per 20litres. Direct water vendors (wells owners) charged 50TZS per 20litres and 100TZS per 20litres. For the houses which were connected with water pipes from the wells, a fixed cost of 5000 TZS was charged monthly (Table 2).

Table 2: water price in Nyambwera and Tamla Street

<i>Water sources</i>	<i>Price (TZS)</i>
<i>Pushcart water vendor</i>	<i>200 – 500 per 20 litres</i>
<i>Neighbor connection from well</i>	<i>5000 TZS per 1000 litres tank</i>
<i>Water kiosk</i>	<i>50 – 100 TZS per 20 litres</i>
<i>DAWASCO</i>	

Households who purchased water from water vendors in general pay 4-10 times more than those who purchase directly from water sources. This puts more pressure on the urban poor because of the hiked water costs. In line with the findings of the present study, [25] reported that dwellers who obtain water from water vendors pay from 10 to 40 times more than those who have own connections depending on condition of supply and location of consumers. [8] reported that fresh water which is bought directly from DAWASCO was much cheaper than salty water. He contended that vendors get more troubles to get salt water than securing fresh, good quality water and therefore the difficulties encountered in getting the water dictated the price of water rather than the quality. Dar es Salaam residents who get water supply from private agents end up paying more than those getting water from formal water supply companies [15].

3.5 Distance between pit latrines and wells

Nyambwera and Tamla sub-wards depend on wells as the main source of water. It was observed that the distance between the wells and the pit latrines for most of the wells (24 out of 25) is less than 10 meters (Table 3).

Table 3: Distance between wells and pit latrines

Distance (Meter)	Number of wells	Accepted distance (Meter)
1-3	2	30
4-6	12	30
7-9	10	30
10-12	0	30
13-15	0	30
15+	1	30

Most plots in the study area are small. Plot coverage is almost over 90% due to high population density. Therefore, the amenities including pit latrines and the wells must occupy the small available space and consequently these two amenities are placed in close proximity (Figure 3). The QQ plot carried-out revealed that the data on the distance between pit latrines and the wells are normally distributed. The z test carried-out showed that there was a significant difference

273 between acceptable distance between pit latrines and the wells and the observed distance
274 ($p < 0.001$) with z statistics = -33.7. This implies that the well operators have grossly violated the
275 set sanitation standards and thereby pose the health threat to the neighboring population.

276
277 These findings are in line with the findings of Ngindu (2007) who revealed that most of the
278 households in Kenya were depending on water from wells that are in close proximity to pit
279 latrines. About 38% of the wells were placed at a distance between less than 15m (The
280 commonly used guideline requires a distance of at least 15m) in Kenya. Most (about 59%) of the
281 wells were estimated to be within the distance of between 15 and 30m from pit latrines. [26]
282 further reported that the analysis of coliforms in waters collected from shallow wells and deep
283 wells showed that the water was highly contaminated with fecal matter while samples from taps
284 had negative total coliform. The results showed that well water is associated with high risks of
285 contamination. However, this work did not determine the concentration of coliforms in wells and
286 this requires further research.

287
288 Since the distance between the pit latrines and the wells is less than the accepted standard of 30
289 m [27] (Table 4; Figure 3a; Figure 3b), there is a high risk that the water can be contaminated by
290 fecal matters because the soils in the site are sandy in texture. Figures 3a and 3b show the extent
291 of spatial proximity between pit latrines and shallow wells.

292

293 Table 4: Distance between wells and pit latrines

Well code	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y
Distance (m)	21	5	5	6	4	3	7	6	7	4	9	5	9	8	8	8	8	3	8	6	6	7	5	5	5
Accepted standard (m)	30																								

294

295 Sandy soil which is dominant in the case study areas is permeable and allows rapid movement of
296 liquids. The risks of contamination corroborate very well with the presence of water borne
297 disease such as Typhoid and Diarrhea in the area as explained by ward executive officers and the
298 household respondents. Similarly, [15] reported concerns of possible contamination of shallow

299 well waters in Yombo Dovya and Tungi informal settlements in Dar es Salaam, Tanzania. The
 300 author observed further that further densification of the informal settlements is likely to increase
 301 the risks of contamination. The

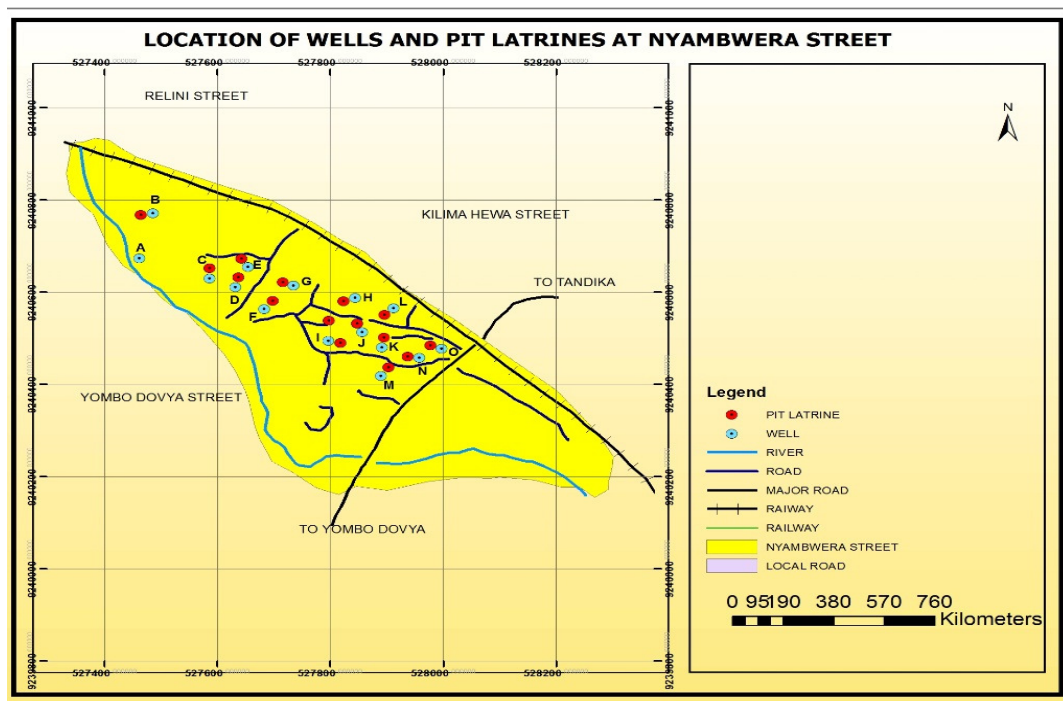


Figure 3a: Distance between well and pit latrines at Nyambwera Sub-ward

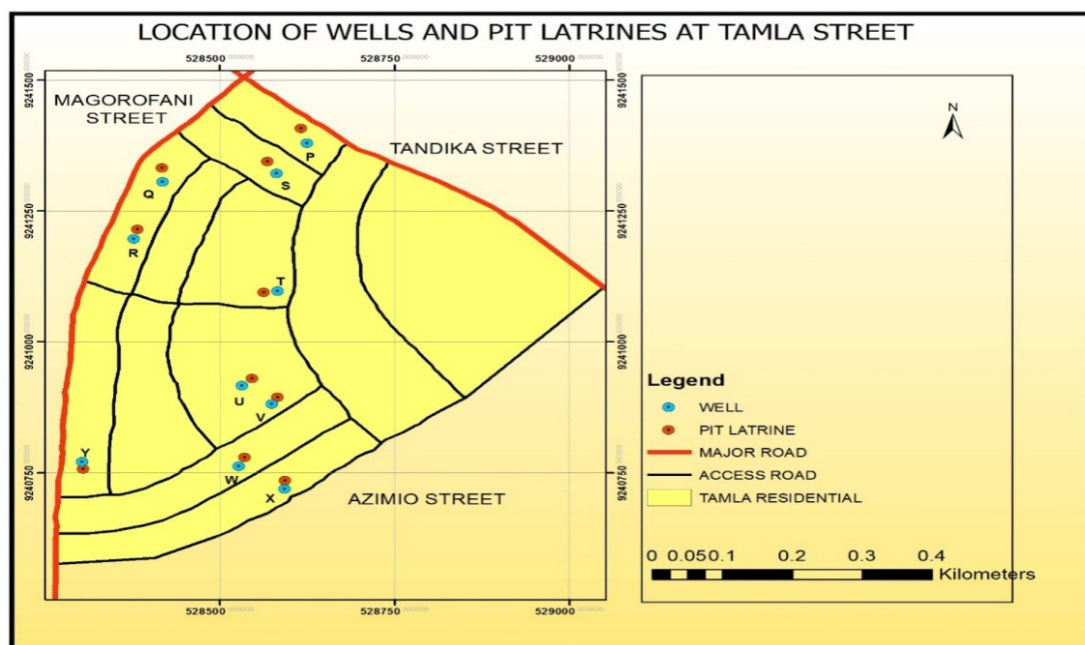


Figure 3b: Distance between well and pit latrines at Tamla Sub-ward

prevalence of water borne diseases, which in principle could be easily controlled, put a lot of pressure on the costs of living to the urban poor. In South Africa, social and health costs of diarrhea accounts for about 1% of the GDP [28]. The closer to the contamination sources (such as pit latrines) the wells are, the higher the risks of contamination. The number of bacterial counts (coliforms) in water wells was significantly negatively correlated with the distance between wells and pit latrines [29]. This testifies that the farther away from the pit latrines the wells are, the safer the wells and vice versa.

During interviews, all the respondents who depended on water from wells reported to have suffered from water borne diseases. From 2013 to 2015, the total number of patients who suffered from water borne diseases in the case study area was 2,266. This is a testimony that improvement in water and sanitation is of paramount importance in improving the quality of life of human beings [30]. Water from shallow wells is prone to contamination from different kinds of pollutants. For example, [31] reported elevated levels of coliforms, aluminum, copper, iron and manganese in shallow wells compared to deep wells in Ndola, Zambia. The concentrations of these pollutants exceeded the WHO acceptable levels. The authors concluded that shallow water wells in Ndola, Zambia were associated with high health risks.

3.6 Perception or residents on the safety of well water

From the data collected, the majority of households (92.5%) were not treating the water before drinking it despite the high risk of water borne diseases such as diarrhea and typhoid witnessed in the community (Table 5).

Table 5: Top five disease in Nyambwera and Tamla Sub-wards

Diseases	Reported cases		
	2012	2013	2014
Malaria	400	320	200
Diarrhea	200	250	360
UrinaryTrack infection	109	312	400
Typhoid	400	544	512

333

334 The residents had the perception that water from the wells was safe and therefore it did not need
335 any treatments prior to consumption. Diarrhea was among the top five diseases that people were
336 suffering from. Others include malaria, acute respiratory infection, pneumonia, urinary tract
337 infection, anemia and typhoid. Only 7.5% of the households were boiling the water before
338 drinking. [26] reported that despite the short distance estimated between the pit latrines and the
339 wells, only 42% of those reported using wells boiled the water for drinking. Those who were
340 boiling drinking water cited contamination as a possible source of waterborne diseases. Water
341 contamination agents in the wells in the area included children dipping dirty objects into the
342 wells, drawing water from the sources with dirty containers, domestic animals defecating around
343 water sources and people washing clothes near the wells. No respondent who use well waters
344 mentioned closeness of the wells to the pit latrines as a possible source of contamination. This
345 implies that residents may continue digging wells in close proximity to pit latrines due to low
346 awareness on the potential danger of contamination.

347

348 Spearman's correlation analysis showed that there was a significant relationship between
349 perception of safety and the treatment of water ($p=0.001$). This shows that those who were aware
350 of the quality of water and its relationship with water borne diseases, treated water while those
351 who were not aware of the possible sources of contamination did not treat the water. This finding
352 should be used as a wakeup call by health officials on the need to intensify awareness campaigns
353 so that the community is educated on the different ways of preventing water borne diseases. It
354 was revealed that 92.5% of the house hold respondents were not treating water in any way. This
355 explains the persistence of water borne diseases in the area. Households failed to treat the water
356 because they were not aware of the possible sources of contamination as explained above.
357 Furthermore, when asked as to why they did not treat water, they pointed out that they cannot
358 afford the costs of charcoal and other sources of energy. In line with the findings of the present
359 study, [32] reported a relationship between treatment of drinking water and the average monthly
360 income of the respondents. This is a testimony that it is easy for the high income earners to
361 afford the cost of chlorinating drinking water as opposed to low income earners.

362

In conclusion, majority of the respondents do not treat drinking water due to the fact that they are not aware of the potential dangers of contamination of the water they use. This shows that households are unaware of health risks associated with consuming water from wells which are located in close proximity to pit latrines. High population density in the informal settlement as witnessed in the case study areas at Nyambwera and Tamla Sub-wards, limited space for erecting sanitary facilities at the plot yards including water wells and pit latrines pose a potential health risks to the inhabitants.

The study recommends for close cooperation between sub-ward leaders, ward officer and health officials to prevent drilling of wells in close proximity to pit latrines. Health officials should provide education to households concerning health risks associated with consuming such water. Those who own the wells should be provided with education on treating water before selling it to consumers. DAWASCO should provide Water Kiosks in areas which have no piped water.

References

Muzondi L. Sustainable Water Provision in Informal Settlements: A Developmental Challenge for Urban South Africa. *Mediterranean Journal of Social Sciences*. 2014; 5; 102 – 207.

2. Osumanu KI, Abdul-Rahim L, Songsore J, Braimah FR, Mulenga M. Urban water and sanitation in Ghana: How local action is making a difference. *Human Settlements Work Paper Series 25*. Water and Sanitation 2010.

4. Gronwall JT, Mulenga M, Mc Granahan G. Self-supply and Poor urban dweller. *Human Settlements Work Paper Series 26*. Water and Sanitation. 2010.

4. Banerjee S, Skilling H, Foster V, Briceño-Garmendia C, Morella E, Chfadi T. Africa infrastructure country diagnostic ebbing water, surging deficits: Urban Water Supply in Sub-Saharan Africa. Background paper 12. World Bank and Water and Sanitation Program. 2008.

5. United Republic of Tanzania (2002). National water policy. 2002.

6. Cain A, Mulenga M. Water service provision for the peri-urban poor in post conflict Angola. *Human Settlements Working Paper Series 6*. Water. 2009.

- 398 Cronin AA, Bresilin, N, Gibson J, Pedley S. Monitoring source and domestic water quality in
399 parallel with sanitary risk identification in Northern Mozambique to prioritize protection
400 interventions. *Water Health*. 2006: 4; 335 – 345.
401
- 402 7. Jacobsen M, Webster M, Vairavamorthy K (eds.) The future of water in African cities: why
403 waste water?. International Bank for Reconstruction and Development/ International
404 Development Association or The World Bank. 2012.
- 405 8. Kjellen M. From public pipes to private hands, water access and distribution in Dar es
406 Salaam. *Stockholm Studies in Human Geography*. 2006. 330 pp.
407
- 408 9. Cairncross S, Kinnear J. Water vending in urban Sudan, *Water Resources Development*.
409 1991: 7; 267–273.
410
- 411 10. Zaroff B, Okun, DA. Water vending in developing countries, *Aqua*. 1984: 5; 289–295.
412
- 413 11. ADB. Water utilities Data Book – 1st Edition, Asian and Pacific Region, Asian Development
414 Bank. 1993.
415
- 416 12. Saravanan VS. Water supply and sanitation as 'preventive medicine': challenges in rapidly
417 growing economies. *Water International*. 2013: 38; 867-874.
418
- 419 13. Vairavamorthy K, Gorantiwar SD, Mohan S. Intermittent water supply under water scarcity
420 situations. *Water International*. 2007: 32; 121-132.
421
- 422 14. Mayala BK, Mboera LEG, Gwacha F. Mapping of cholera risks using geographical
423 information system in Ilala District, Tanzania. *Tanzania Health Research Bulletin*. 2003: 5; 8 –
424 13.
425
- 426 15. Kyessy A. Community-Based Urban Water Management in Fringe Neighbourhoods: The
427 Case of Dar es Salaam, Tanzania. 2005: 29; 1 – 25.
428
- 429 16. United Republic of Tanzania. National Population Census. 2002
430
- 431 17. Reweta WSJ, Sampath, RK. Performance Evaluation of Urban Water Supply in Tanzania:
432 The Case of Dar Es Salaam City. *International Journal of Water Resources Development*.
433 2000:16; 407–423.
434
- 435 18. Onestini M. Water Quality and Health in Poor Urban Areas of Latin America. *Water*
436 *Resources Development*. 2011: 27; 219–226.
437

- 438 19. Sanar R, Filadoro LYM, Khusainova V. Access to water in developing countries: four options
439 for provision and regulation in the water sector. *Asia Pacific Journal of Public Administration*.
440 2015: 37; 196 - 206
441
- 442 20. Mashauri DA, Katko TS. Water supply development and tariffs in Tanzania: from free water
443 policy towards cost recovery. *Environmental Management*. 1993: 17; 31–39.
444
- 445 21. Howard G, Teuton J, Luyima P, Odongo R. Water usage patterns in low-income urban
446 communities in Uganda: implications for water supply surveillance. *International Journal of*
447 *Environmental Health Research*. 2002: 12; 73 – 13.
448
- 449 22. Whittington D, Lauria D, Mu X. A Study of water vending and willingness to pay for the water
450 in Onitisha, Nigeria. *Paying for urban services*. 1991.
451
- 452 23. Grönwall JT, Mulenga M, Mc Granahan G. Groundwater, self-supply and poor urban
453 dwellers. A review with case studies of Bangalore and Lusaka. *Human settlements Work*
454 *Paper Series 26. Water and Sanitation*. 2010.
- 455
- 456 24. Ishaku TH, Peter AA, Dama FM. The role of private water vending in Nigerian peri urban
457 informal settlements. *Journal Water Resource and Protection*. 2010: 2; 1082 – 1087.
458
- 459 25. Kjellen M, Mcgranahan G. Informal water vendor. *Journal of Human Settlement discussion*
460 *paper series. Theme Water-3. International Institute for Environment and Development (IIED) 3*
461 *Endsleigh Street, London WC1H 0DD, United Kingdom*. 2006.
462
- 463 26. Ngindu MA, Murage E. Quality of Water the Slum Dwellers Use: The Case of a Kenyan
464 Slum. *Journal of urban health*. 2007: 84; 829 - 838.
465
- 466 27. Ernest AA Effect of pit latrines on dug well water quality. A case study of the Asankrangwa
467 Community in the Wassa Amenfi West district of Ghana. A thesis submitted to the Department
468 of Environmental Science in partial fulfillment of the requirements for the degree of Master of
469 Science in Environmental Science. 2013.
470
- 471 28. Pegram GC, Rollins N. Espey Q. Estimating the costs of diarrhoea and epidemic dysentery
472 in Kwazulu-Natal and South Africa. *Water SA*. 1998: 24; 11–20.
473
- 474 29. Sangodoyin AY. Considerations on contamination of groundwater by waste disposal
475 systems in Nigeria. *Environmental Technology*. 1993: 14; 957 – 964.
476
- 477 30. Waddington H, Snilstveit B. Effectiveness and sustainability of water, sanitation, and
478 hygiene interventions in combating diarrhoea. *Journal of Development Effectiveness*. 2009: 1;
479 295-335.

- 480
481 31. Liddle S. The suitability of shallow hand dug wells for safe water provision in Sub-Saharan
482 Africa: Lessons from Ndola, Zambia. *Applied Geography*. 2015: 57; 80 – 90.
483
- 484 32. Sasaki S, Suzuki H, Igarashi K, Tambatamba T, Mulenga P. Spatial Analysis of Risk Factor
485 of Cholera Outbreak for 2003–2004 in a Peri-urban Area of Lusaka, Zambia. *The American*
486 *Journal of Tropical Medicine and Hygiene*. 2003: 79; 414 – 421.